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Linguistic Minorities & Society Journal/Revue Minorités linguistiques et société

DOI:

<https://doi.org/10.7202/1078478ar>

Published: 13/08/2021

Peer reviewed version

[Cyswllt i'r cyhoeddiad / Link to publication](#)

Dyfyniad o'r fersiwn a gyhoeddwyd / Citation for published version (APA):

Prys, C., Hodges, R., & Roberts, G. (2021). Rhetoric and reality: critical review of language policy and legislation governing official minority language use in health and social care in Wales. *Linguistic Minorities & Society Journal/Revue Minorités linguistiques et société*, (15-16), 87-110. <https://doi.org/10.7202/1078478ar>

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Abstract

A concerted attempt is being made by the Welsh Government to revitalise the Welsh language in Wales through language legislation and policy initiatives. This paper will assess the implementation of those recent legislative development designed to improve the nature and reach of Welsh language services across the healthcare sector. The paper offers an analysis of written evidence provided by key stakeholders during the consultation process on the new legally-binding requirements or Welsh Language Standards for healthcare providers across Wales. Tasked with implementing Welsh language legislation and policy, we argue that these meso level service providers are critical linchpins within the healthcare system, and that it is at the meso level that the full tensions between the macro rhetoric and micro reality are fully played out. This paper highlights shortcomings and barriers to the provision of Welsh language services in healthcare in Wales; and calls for the adoption of wide, holistic approaches to language planning that meet the language needs of patients.

Keywords: health and social care; language planning; minority language; Welsh; Wales

Background

The Welsh language is the oldest spoken language of the British Isles and one of the most ancient literary languages in Europe (Jenkins and Williams, 2000). According to the 2011 Census, 19% of the population of Wales are able to speak Welsh, which equates to approximately 562,000 Welsh speakers (ONS, 2012); whilst 13% are reported to use the language on a daily basis (WG & WLC, 2015). It is understandable, therefore, that Welsh is often referred to as a minority language within Wales. Nonetheless, since 1991, there has been a steady increase in the number of young Welsh speakers in Wales, with 40% of 5 – 15 year olds reported to speak the language in 2011 (ibid). Along with this generational variation, regional differences are also found in the percentage of Welsh speakers living in Wales, with 65% in the county of Gwynedd, 57% on the Isle of Anglesey, and 47% in Ceredigion. The lowest percentage of people speaking Welsh in 2011 was found in Blaenau Gwent at 7.8% (ONS, 2012), thus demonstrating that Welsh speakers are present in every local authority across the country.

Welsh-medium and bilingual education in Wales have made a substantial contribution to the numbers of Welsh speakers in Wales (Hodges 2012; Thomas and Williams, 2013). Since the 1988 Education Reform Act, Welsh is a compulsory subject within the National Curriculum for pupils up to the age of 16 years old (Jones, 2016). It is taught either as a first language in Welsh-medium schools or as a second language in English-medium schools¹. Sixteen per cent of pupils in Wales attend Welsh-medium schools, with a further 10 per cent attending schools that are bilingual, dual-medium, or English-medium schools with significant Welsh provision (StatsWales, 2017). However, despite this measure of success, the education

¹ Following the Donaldson Report of 2015 there are plans to significantly revise the school curriculum in Wales by 2020. One recommendation is to abolish second language teaching of Welsh in schools and teach Welsh as a first language in all schools in Wales (https://dera.ioe.ac.uk/22165/2/150225-successful-futures-en_Redacted.pdf)

system has been criticised for its lack of forward planning and its failure to create more Welsh speakers that could provide an active bilingual workforce (WG, 2010). This, of course, has an impact across the public sector, especially health, where recruiting healthcare professionals with sufficient bilingual skills is paramount for ensuring quality care (WG, 2016) .

Whilst Welsh is considered a vulnerable language by UNESCO (Moseley, 2011), it can be argued that a concerted effort has been made to revitalise the language by halting the decline in the number of speakers of Welsh. This can be seen in the most recent language strategy of the Welsh Government (WG), ‘Cymraeg 2050’ (WG, 2017), which outlines the ambitious goal of almost doubling the number of Welsh speakers by 2050. This relatively recent goal can be seen as the latest development in the upwards trajectory of the Welsh language in Wales, from a marginalised language of home and private life, to a language of governance, public services and education.

It is against this legal and linguistic backdrop that health and social care services in Wales are provided, where Welsh language provision has emerged as a key element within policy and planning. In the bilingual context of Wales, an ‘active offer’ of health and social care services in Welsh is seen as a method of delivering safe, dignified, quality care, as outlined in the WG’s recent strategic framework, aptly named, ‘More than just words’ (WG, 2012, 2016). Adopting a whole-system approach, it guides the planning and delivery of Welsh language services, with an emphasis on integrating systems and processes for workforce development, whilst establishing favourable conditions to support the ‘active offer’ principle.

In line with these legislative and policy developments, Welsh Language Standards (WLS) were placed on all local authorities in Wales (social care commissioners and providers) in 2016 (WG, 2015a) ; and, more recently, further standards were introduced to local Welsh health boards and NHS trusts (health care providers) in 2019 (WG, 2018a). The standards outline the role of organisations in relation to their Welsh language provision; and offer clarity to Welsh speakers on what services they can expect to receive in Welsh. In the health sector, which is the focus of this paper, the publication of the draft WLS attracted wide interest and intensive debate, prompting scrutiny from a number of key stakeholders. The exemption of independent primary care services (e.g. general practitioners) has called into question the potential reach and suitability of the legislation, with a plea for a more comprehensive approach. Nonetheless, amidst concerns about the language capacity of the workforce and regional variations therein, healthcare providers and bodies representing health professionals have questioned the viability of delivering some of the Welsh language provision outlined in the standards.

This paper will explore the tension between the WG's rhetoric and the reality of current language legislation in Wales. It will examine how the WG strikes a balance between providing Welsh language services to the people of Wales, and the reality of doing so within a minority language context. This will be achieved by analysing the responses of stakeholders during the consultation process on the WLS for the health sector between 2018 and 2019.

Welsh Language legislation

Although Welsh, as a minority language, has historically struggled for official recognition in Wales, its status has increased over the past three decades with the Welsh Language Acts of 1967 and 1993, and the more recent Welsh Language Measure (2011), representing the

progression of Welsh language legislation in Wales. The Welsh Language Act (1993) placed a duty on public bodies in Wales, including local health boards, to treat the Welsh and English languages on a basis of equality as set out in their Language Schemes. Nonetheless, it was argued that the Act was limited in scope (Dunbar 2009, Williams and Morris, 2000, Vacca, 2013) as it contained a clause that allowed the concept of equality to be relevant only when it was 'reasonable' and 'practical' (1993: 03). Furthermore, the lack of oversight for the implementation of the Act was also criticized, leading to calls by some for more rigorous legislation to protect the language rights of Welsh speakers while accessing public services, such as healthcare.

Since 1999, Wales has a devolved legislature within the United Kingdom, with decision making powers on issues including the Welsh language as well as health and social care (Royles, 2007). Subsequently, the transfer of social policy-making from a centralised to a non-centralised government heralded a policy paradigm shift that included language policy within mainstream social policy for the first time in Wales (Carlin & Mac Giolla Chríost, 2016; Lewis & Royles, 2017 and Williams, 2011).

Following devolution, the Welsh Language (Wales) Measure was enacted by the WG in 2011. The Measure creates a new legislative framework for the promotion of Welsh, where the language now has official status in Wales, and should be treated no less favourably than English within the public sector (WG, 2011). The Measure also creates standards of conduct that relate to the use of Welsh within a variety of contexts, including service delivery and policy making (ibid). Furthermore, the role of Welsh Language Commissioner (WLC) was created to promote the use of Welsh and oversee and enforce compliance with the Measure.

The paradigm shift (Williams 2011) is evident when discussing the place of Welsh within the broader health and social care agenda that has also been developed in recent years. The WG's Well-being of Future Generations (Wales) Act 2015 (WG, 2015b) placed a legal duty on public bodies to assess the effect of policy decisions on wellbeing. The role of language, and its influence on wellbeing is presented as one of the 7 wellbeing goals found within the Act. In a further example, *A Healthier Wales* (WG, 2018b) action plan was published by the WG outlining the role of Welsh within the health and social care sector and identifying the Welsh language as an area of priority. These developments can be seen as attempts to mainstream the use of Welsh within public sector services, and the health sector in particular, and represent the multifaceted approach taken by the WG in embedding Welsh language services within health and social care. Nonetheless, salient questions remain regarding the extent of their implementation within various strategies and policies relating to the Welsh language in healthcare.

The Welsh language in health and social care

At the very epicentre of health and social care services is caring for people as individuals and placing the service user at the heart of those services. Although language is an essential communication tool in order to convey symptoms and emotions, it is also crucial in expressing one's identity, culture and true sense of belonging (Gregg and Saha, 2007), especially when individuals are frail or unwell. Indeed, a plethora of research highlights the importance of responding appropriately to language needs in healthcare to ensure the safety and quality of service provision (e.g. de Moissac & Bowen, 2019; Jacobs et al., 2006).

In the bilingual context of Wales, the impact of language in health and social care has been an area of growing interest for academics and policy makers alike. The first seminal report on

the position of Welsh language services across the sector was published by Misell in 2000. Based on his systematic review, Misell (ibid) concluded that the Welsh language was invisible when planning and providing health and social care services in Wales. This leads to substantial shortcomings where service providers disregard the linguistic needs of their patients and clients, and in doing so, undermine the safety, quality and efficiency of their services. Misell (ibid) concludes that these shortcomings place Welsh speakers at a disadvantage and notes that this is particularly damaging for those who are vulnerable, such as individuals with; mental health problems, learning difficulties, elderly people and young children. Based on the recommendations of this study, the WG created a task force to promote the use of Welsh within the sector. Nonetheless, studies conducted during the past two decades suggest that shortcomings remain, and that the lack of Welsh language provision continues to place Welsh speakers at risk.

With a focus on mental health service provision, Madoc-Jones (2004) noted that language sensitive services are integral to the requirements of Welsh speakers, although current provision did not meet the needs of this client group. In their study of language awareness amongst healthcare providers, Irvine et al (2006) also noted that many professionals are aware of the benefits of offering Welsh language services to their patients. However, their findings suggest that the language needs of patients were generally not taken into consideration at an organisational level. This led to a number of shortcomings in the provision of Welsh language services across the sector.

With a focus on third sector service providers, a study by Prys (2010) concluded that Welsh speakers received a better service in their language of need. However, these service users were seldom offered a language choice and, due to the vulnerable nature of the individuals

involved, were unlikely to ask for, or demand a service in Welsh. More recently, Iaith (2012) published a report on the experiences of Welsh speakers accessing health and social care services. Their findings offer further evidence of the lack of availability of bilingual services, which ultimately undermines the quality of provision for Welsh speakers of all ages. Furthermore, Beaufort (2014) concluded that Welsh language provision in healthcare is inconsistent, with both the nature of the service and its geographical location within Wales influencing its availability. The study reported that less than one in twenty respondents were offered a language choice by their healthcare provider, and there was a sense of acceptance amongst service users that they were not able to access Welsh language provision (Beaufort, 2014). During the same year, the WLC (2014) published a statutory inquiry into the use of the Welsh language within primary care. The inquiry focused on the lived experiences of patients and offers further evidence of “worrying experiences that Welsh speakers and their families have had to face in not being able to access healthcare appropriate to their needs.” (2014, p. 4). Nonetheless, the inquiry further acknowledges that offering Welsh language services is intrinsically linked with offering quality care for Welsh speakers.

Despite such stark evidence, several studies that followed the inquiry continued to report on the importance of language as an element of effective healthcare provision and the persistent shortcomings found in Welsh medium provision, particularly in mental health services (Hughes, 2018), and dementia care (Alzheimer's Society Cymru & WLC, 2018). On the basis of their scoping review of the implications of culture and language for the caregiving of residents with dementia in care homes, Martin et al (2018, p. 109) concluded that “discrimination against the Welsh language leads to under-recognition of the needs of Welsh-speaking people accessing health and social care services”. Once again, the study points to the

positive impact of Welsh language provision, whilst outlining that contiguity between Welsh speakers and Welsh language services continue to be lacking.

It is against this backdrop that the WG and its partners have published and adopted a number of strategies to mainstream the use of Welsh within the health and social care sector in Wales. The WG's strategic framework 'More than just words' (2012 and 2016) exemplify its attempt to implement new strategies to further mainstream the use of Welsh within health and social care. Nonetheless, despite developments in language legislation and the implementation of policies to promote Welsh, the current research suggests that there is a lack of parity between the Welsh and English language within the sector, and that this can disadvantage Welsh speakers' health and wellbeing.

From language choice to the 'active offer'

In light of Misell's (2000) seminal report and the growing body of evidence, offering a language choice (English or Welsh) to patients was soon identified as a mechanism for providing language sensitive services within healthcare provision. This can be seen as a manifestation of wider neoliberal policies within the healthcare sector, based on the notion that, as Le Grande states, "Equity depends on the extent of individual choice" (1991, p. 176). However, an individual's ability to make certain linguistic choices within specific contexts (e.g. health services) has been criticized (Williams and Morris, 2000, Davies, 2009, Prys, 2010). As Davies notes "although bilingual individuals appear to be in a position of choice in relation to which language to use, the choice may not always be a free choice or even a conscious choice for the individual, especially when one of those languages is considered a minority language" (2009, p. 3).

Moreover, for individuals who are particularly vulnerable, due to their age, cognitive ability or psychological state, it is argued that language is often a matter of clinical need rather than choice (Misell 2000, Prys 2010, Iaith 2012, WLC 2014). Mirroring developments in Canada (Drolet et al., 2017) is the policy of offering patients and clients an ‘active offer’ of Welsh language services which means “providing a service in Welsh without someone having to ask for it... creating a change of culture that takes the responsibility away from the individual and places the responsibility of service providers and not making the assumption that all Welsh speakers speak English anyway (WG, 2016, p. 11).

This is the core principle of the WG’s ‘More than just words’ (2016) strategic framework for health and social care services in Wales. The strategy outlines that it is “committed to delivering high-quality health, social services and social care services that are centred on people's needs and outcomes”(WG, 2016, p. 8).

Although the ‘active offer’ principle is embedded in the WLS, it is evident that successful and consistent implementation requires a higher level of scrutiny than that outlined in the strategic framework policy.

Welsh Language Standards in healthcare

Following a four-year period of intense scrutiny, which prompted wide and contentious debate, the standards relating to the healthcare sector were finally approved by the WG in 2018, thereby authorising the Welsh Language Commissioner to impose compliance notices to service providers. The process was initiated in 2014 by a standards investigation, led by the Commissioner, to ascertain the readiness of service providers to comply with imposed directives relating to Welsh language provision in service delivery, such as correspondence and telephone calls; policy making, such as formulating or revising policies; operational

procedures, such as human resource management and training; and record keeping, such as complaints and compliance. As a result, draft regulations were published in 2016 and subject to a public consultation, prompting concerns about their potential application, limitations and reach (WG, 2018c). Whilst, in response, the WG was keen to emphasise the demands already placed on healthcare organisations to plan services within the wider policy context of Welsh language provision, the final regulations, published in 2018 (WG, 2018a), offered a stark compromise with regard to service delivery so that clinical consultations were exempt. Moreover, although over 90% of healthcare provision in Wales is delivered through primary care services (Auditor General for Wales (2018), the vast majority of providers are independent practitioners where the standards do not apply. Thus, contrary to the spirit of the Welsh Language (Wales) Measure 2011, it is worth noting that that these exemptions deny the rights of citizens to face-to-face clinical services in Welsh in their day-to-day encounters with the health service in Wales. The revised regulations were subsequently scrutinised by the Culture, Welsh Language and Communications Committee of the Welsh Assembly for Wales whereby a number of stakeholder organisations were invited to present evidence (NAW, 2018). The ensuing regulations were adopted by WG in 2018, and standards placed on healthcare providers, such as local health boards, in May 2019. Given the WG's proposal to place a small number of Welsh language duties on independent primary care providers by means of their contractual agreements, these obligations were also scrutinised by the same Committee, adopting a similar process (NAW, 2019), and were adopted in 2019 alongside the standards.

The regulations set the range of standards that could be imposed on healthcare providers; and the Welsh Language Commissioner decides which standards to enforce on each organisation, depending on its Welsh language vitality and the Welsh language demography of the population that it serves. Contrary to the previous Welsh Language Schemes, where

organisations fail to comply with the new WLS, the WLC may take enforcement action, which includes the imposition of a fixed penalty (WG, 2011). This is a noteworthy change in direction from the WG, with a new emphasis placed on the enforcement of language legislation from macro level stakeholders, in this case, the WG and the WLC. These key stakeholders can be seen as language policy and planning drivers tasked with ensuring that meso level service providers implement language legislation and strategies within the healthcare sector in Wales. This paper will assess the interplay between macro level drivers (e.g. legislation and policy) and micro level drivers (service user needs); and examine how meso level service providers mediate both when tasked with providing services in Welsh. This will allow us to explore inconsistencies between government rhetoric and the reality of language legislation in Wales.

The Macro-Meso-Micro Framework

Definitions of language planning have often focused on macro-level planning by national governments (Liddicoat & Baldauf, 2008). More often than not, nation building and securing unity during volatile periods of history seemed key priorities for post-colonial, macro-centric language planning institutions (Fishman, 1974, Rubin and Jernudd, 1971 and Ricento, 2000, 2003). Moreover, definitions of language planning themselves have often highlighted, ‘the marginalisation of micro-level language planning’ (Liddicoat and Baldauf 2008: 03) in favour of macro, power-orientated understandings of language. However, there are increasing calls to consider the implementation of micro language planning initiatives within a variety of contexts (Munro, 2011; Sallabank, 2010; Wilson, Johnson, & Sallabank, 2014). Furthermore, Barakos (2016) amongst others, recognises the role that power and agency play in the lives of social actors and how vital a consideration these elements are in constantly re-shaping language policy implementation worldwide. As a result, it can be argued that language

planning often incorporates a number of crucial players, such as government agencies, pressure groups and key individuals, from macro to meso to micro level language planning (Haarmann 1990). The interaction between these key players highlights the complexity of attempting to implement language policies on a practical level. Indeed, this particular complexity is further compounded within the health sector, as will be discussed further within this paper. Moreover, Baldauf (2006) utilises the macro-micro continuum and notes the spectrum of language planning levels, from top-down government-led language planning strategies to micro-level planning and action by individual social actors. Furthermore, Baldauf notes that meso-level language planning is somewhat difficult to define as it sits between macro and micro-level language planning, but is often the most influential when discussing the interplay between crucial language planning players on a macro and meso level.

Pennycook (2010) emphasizes meso-level as an active site of practice that links the macro and micro levels of language planning. Within the context of Wales, Musk (2010) emphasizes the importance of educational institutions as a meso level site of mediation between macro and micro levels of society and where macro policies are to be implemented. Furthermore, Musk (2010: 45) notes that the meso level can “be seen as a nexus, where circulating discourses are recontextualized and potentially renegotiated by agents, such as teachers and pupils”. As a result, the meso level can be seen as a site of language negotiation, a key linchpin in the language planning process, where government policies and rhetoric are implemented, and at times, challenged.

For the purpose of this paper, we explore the possible tensions between government rhetoric and the reality of implementing health services through the medium of Welsh on a day-to-day

basis. The macro-meso-micro framework (Baldauf, 2006) is one that lends itself well to the health sector and, particularly, Welsh language planning. This framework provides a meaningful context to discussions that highlight the multi-layered, complex nature of this sector. Macro-level planning could be interpreted as the government driving their agenda through Welsh language strategies and key language legislation, such as the WLS. Meso-level planning could represent organisations and professional bodies within the health system interpreting and implementing these Welsh language strategies. Within this framework, micro-level planning could be seen as individuals' and service users' experiences in accessing key services within healthcare and their demands for Welsh language services. The interchange between all three levels is important in understanding the way in which the language of healthcare services are planned, delivered and negotiated. Subsequently, this interchange between levels of language planning also provide important insights into the barriers preventing service implementation. Within this paper, we argue that the meso level of language planning and policy is a critical linchpin within the healthcare system as, more often than not, it is at the meso level that the full tensions between the macro rhetoric and micro reality are fully played out. Subsequently, it could be argued that healthcare, unlike other language planning domains, needs to consider the micro elements of the framework even more closely as patients' lives are often at risk when their language needs are ignored.

Analysis of Stakeholder Consultations

Methods

With a view to exploring the rhetoric around the WLS (WG, 2018a), we focussed exclusively on the following reports:

- The Welsh Language Standards (No. 7) Regulations 2018: Report of the Culture, Welsh Language and Communications Committee under Standing Order 27.8 (National Assembly for Wales (NAW), 2018)
- The National Health Service (Welsh Language in Primary Care Services) (Miscellaneous Amendments) (Wales Regulations 2019) (NAW, 2019)

The first report compiles evidence from stakeholder groups representing i) health service providers (The NHS Confederation); ii) professional groups (British Medical Association (BMA) Cymru Wales; Royal College of General Practitioners (RCGP) Cymru Wales); health service users (Meddwl.org); and campaign groups (Cymdeithas yr Iaith Gymraeg (CYIG) / Welsh Language Society)². The second report presents evidence on behalf of stakeholder groups representing i) professional groups in primary care (BMA Cymru Wales; British Dental Association (BDA); Community Pharmacy Wales (CPW); Optometry Wales (OW)) and ii) campaign groups (CYIG).

For the purpose of this paper, we accessed the full written evidence, analysing the complete data set using thematic analysis (Braun and Clarke, 2006) as a way of identifying emerging themes from the stakeholder consultations; and interpreting conflicting views and ideas.

According to Maguire and Delahunt (2017), this methodological approach is popular within the social sciences because of its systematic framework, flexible approach and freedom of constraint to any particular epistemology or theoretical perspective.

² a group of people who campaign for the Welsh language and communities in Wales, and recognise that the campaign for Wales' unique language is part of a wider world-wide struggle for minority rights and freedoms.

Results

Adopting the 6-step framework proposed by Braun and Clarke (2006), we commenced by familiarising ourselves with the data through reading and re-reading the transcripts. Open coding of each transcript by hand enabled codes to be developed and modified, with new codes being assigned as the work progressed. Several of these codes revealed a close fit and were thus grouped together to represent the main themes emerging from the data. Further discussions led to a review and refinement of these themes, resulting in a final thematic map (Figure 1) that represents the stakeholder perspectives in their entirety.

Six themes emerged from the thematic analysis of the stakeholder consultation on the Welsh language standards, as depicted in the thematic map (Figure 1) and Tables 1 and 2 and these will be presented in turn. (Insert Figure 1, Table 1 and Table 2 here)

Theme 1: Drivers of Welsh language standards in healthcare

Stakeholders readily acknowledged the legal and statutory frameworks driving the standards; and the implications of language appropriate services for quality care.

“Our members welcome the growing recognition of the importance of meeting language needs and the impact this can have on the delivery of safe, high quality care, and a positive patient experience.” (NHS Confederation, 2018, p. 2 in NAW, 2018).

Nevertheless, it was argued that “in the interests of receiving timely or appropriate care, ... it is not always possible or practical for a Welsh-speaking patient to have a consultation with a doctor, or other health care professional, who is able to undertake a consultation with them through the medium of Welsh.” (BMA Cymru Wales, 2018, p. 2 in NAW, 2018).

This concern raised doubt about the scope of the standards, with the WG accused of “giving way to the self-interests of organisations rather than prioritising the needs of service users.” (CYIG, 2018, p. 1 in NAW, 2018).

Theme 2: Perceived risks of Welsh language standards in healthcare

Respondents reported that constraints within the NHS are likely to mitigate against the standards, with deficits in the Welsh language capacity of the workforce leading to potential delays, additional (translation) costs and risks to clinical safety.

“The requirements are onerous and expensive as currently stated in the standards. This will add extra bureaucracy to an already weighed down system.” (BDA, 2019, p. 31 in NAW, 2019)

Such concerns have prompted optometrists “to advise practitioners not to conduct sight tests or clinical examinations in any other language other than the language in which they studied. We have concerns about the medico-legal implications of delivering clinical examinations and advice in any language other than English.” (OW, 2019, p. 37 in NAW, 2019).

Nevertheless, others suggested that failing to meet language needs also poses a threat to clinical safety. For example, in the context of mental health services, “the decision to remove Welsh language support in clinical consultations enables health bodies in Wales to neglect the needs of those where there is no 'scan' or ‘obvious treatment ’ for their conditions, and where clear communication is absolutely crucial in ensuring accurate diagnosis, effective treatment and recovery.” (Meddwl 2018, p. 4 in NAW, 2018).

Theme 3: Workforce implications of Welsh language standards in healthcare

Concerns about the Welsh language capacity of the workforce prompted debate about the scope of training and development to enhance language skills; viewed by the NHS Confederation (2018, p. 12 in NAW, 2018) as “... simply not feasible given the tight financial restrictions...”

Nevertheless, stakeholders identified workforce planning and commissioning as a way forward, with an emphasis on i) the targeted recruitment of Welsh speakers:

“The Committee should consider the bigger picture and the need for training a Welsh-speaking workforce. We therefore recommend that quotas should be imposed on medical schools and other training colleges in terms of training doctors, nurses and other health workers who can speak Welsh.” (CYIG, 2018, p. 7 in NAW, 2018)

and ii) bilingual provision in professional registration programmes: .

“The solutions to these challenges often go beyond the remit of Health Boards and Trusts, with the importance of having a truly bilingual education system at the core of the issue.” (NHS Confederation, 2018, p. 11 in NAW, 2018).

Theme 4: Systems to support Welsh language standards in healthcare

Stakeholders suggested that organisational systems are a barrier to the implementation of the standards. Respondents raised concerns about the readiness of patient administration and electronic systems to deal with two languages, as outlined by the NHS Confederation (2018) in NAW (2018):

“...there are several data systems within Health Boards and Trusts which are not compatible with each other.” (p. 5). Moreover, “...not all patient administration systems currently have the facility to record language choice....” (pg 4); and some departments / clinics also record their data exclusively via paper systems, which would make language choice onerous and difficult to transfer.” (p. 5).

Nevertheless, CYIG (2018, p. 43) noted that “With the move towards integrating primary and community care provision, it is expected that there will bilingual electronic systems in place that will enable the recording of the ‘active offer’ and patients’ language requirements.”

Theme 5: Monitoring and planning for Welsh language standards in healthcare

This theme reflects a debate about the urgency of planning and monitoring universal Welsh language provision across care pathways as a way of ensuring the continuity of the ‘active offer’, particularly amongst vulnerable groups. The NHS Confederation (2018) in NAW (2018) suggests that this move is fraught with difficulties since:

“... some of these Standards are immeasurable, which means that it is extremely difficult for Health Boards and Trusts to monitor the extent to which the Standards are being implemented across such a large, diverse and multidisciplinary organisation across a range of services.

Monitoring the Standards could also prove to be difficult to achieve as to ensure consistency across the organisations due to the complexity of the organisational infrastructure.”(p. 10).

CYIG (2018) in NAW (2018) challenge these perceptions, suggesting that the Welsh Language Commissioner should have an official role in the monitoring process, particularly in relation to primary healthcare services.

Theme 6: Care sector implications for Welsh language standards in healthcare

Stakeholders reported divided opinions about the Welsh language duties placed on independent primary care providers. Concerns about workforce capacity led some respondents to question the reality of these contractual obligations.

“... whilst we remain supportive of the aspirations of the legislation, it is appropriate to state that the ongoing and much publicised pressures on general practice in Wales (and beyond) means that some practices will struggle to fulfil some, if not all, of the duties.” (BMA, 2019, p. 23 in NAW, 2019)

Meanwhile, others argued about the injustice of exemptions that have such a negative impact on a wide range of service users, particularly those who are vulnerable.

“There will be a number of mental health patients who go on to receive specialist services and whose first point of contact with health service is through a primary care provider, such as their GP. Understandably, it is of concern that the individual will have no Welsh language entitlement when accessing primary care services.” (Meddwl, 2018, p. 4 in NAW, 2018).

Discussion

Utilizing the macro, meso, micro framework (Baldauf, 2006), this paper offers insight into the debate surrounding Welsh language provision in healthcare in the bilingual context of Wales. Findings from this study highlight the role of macro-level drivers (in the form of

language legislation and policy) and their influence on the delivery of Welsh language services within the healthcare sector. Stakeholders who took part in the consultation recognise the legislative framework outlined within the Welsh Language Measure (WG, 2011) and the WLS (2018); and the positive influence of language concordance on patient care. Indeed, this can be interpreted as an outcome of the multipronged approach adopted by the WG which embeds Welsh language provision within various policy and legislative contexts (as mentioned earlier by Williams 2011), including bespoke language legislation (e.g. Welsh Language Measure 2011), and within the more generalised legislative context, such as the Wellbeing Act (2015) and the Healthier Wales Plan (WG, 2018b). This also suggests that key messages from the WG's strategy 'More than Just Words' (WG 2012, 2016) have also influenced the narrative and agenda within the sector. These examples highlight a sense of harmony between macro and meso level influences, and suggest that a level of consensus has emerged within the sector relating to the importance of Welsh within the patient experience. Nonetheless, closer examination of the stakeholder responses suggest that this consensus can be interpreted as, limited at best, and at worst, strained.

Several of the meso-level service providers who took part in the consultation point to tensions and barriers relating to the delivery of Welsh language services in healthcare. Moreover, they outline the perceived threats to service delivery if stringent Welsh language standards were indeed placed upon the sector. Among these were concerns regarding possible delays in service provision, patient safety, additional expense, added bureaucracy, and the lack of electronic systems to enable the recording of patients' language requirements. Thus, the response from service providers can often be seen to counteract the rhetoric and the ambition of macro-level language planners as they attempt to strengthen the position of Welsh within the sector. Crucially, some of the concerns raised by service providers, such as Optometry Wales, were based on perceived "medico-legal implications" (WG 2019:37) which were

deemed to impact the legal standing of healthcare professionals. Nevertheless, this narrative is at odds with much of the rhetoric found within the sector that emphasises that the patient should be the central concern of care provision (The Health Foundation, 2016).

Further tensions emerge while considering the role of meso and micro stakeholders. Within this study, these tensions emerge between the three distinct groups, that is, the WG (legislation and strategy); service providers tasked with implementing the standards (e.g. BMA and NHS Confederation); and pressure groups representing Welsh speaking service users, who call for more comprehensive Welsh language provision across the sector. In this case, the micro level is represented by CYIG and Meddwl.com, both of whom advocate for the rights of Welsh speakers to use Welsh on accessing healthcare. It could be argued that, whilst meso service providers mainly advocate for their professions, (such as outlining various risks associated with complying with language legislation), the micro level discourse emphasises the obligation to meet the needs of Welsh speaking patients. As a result, meso and micro level stakeholders were often at odds regarding the importance of Welsh language provision in healthcare. Nevertheless, it can be argued that the rhetoric found within the macro WG strategies, can, at times, mirror more closely the micro level discourse of language pressure groups rather than that of meso-level stakeholders. This can be seen most clearly in the content of the WG's *More than just words* (2016) strategy where the WG emphasises the need for Welsh language services to fully support Welsh speakers accessing healthcare. As a result, pressure from various stakeholders within the language planning process can be seen as drivers in the formation and delivery of Welsh language services within the healthcare sector in Wales. (Insert figure 2 here)

As noted previously, we stress that meso-level should be viewed as a critical linchpin within language planning, particularly in the healthcare sector. Indeed, when considering the

content of the WLS, it can be argued that meso level pressures play a decisive role in limiting the reach of Welsh language legislation. The previous exemptions of clinical consultations and primary care can be seen as a result of meso level pressures, dramatically reducing the scope of the legislation and its impact on the experiences of Welsh speakers in their day-to-day encounters with the healthcare sector.

Findings from this study also suggest that meso level service providers have misconceptions regarding the scope and impact of macro level drivers (e.g. the exemption of clinical consultations). This is also reflected in the comments provided by the BDA, who, as representatives of primary care service providers, were exempt from the reach of the measure and associated standards. These misconceptions may have a negative impact on the perceptions of service providers and their readiness to support the strategic drive. This suggests that the WG needs to better support service providers in understanding their obligations under current and future Welsh language legislation. Furthermore, a lack of understanding of language legislation, and the broader role of language within the sector, may also impact on leadership within meso-level service organizations, an area which is emphasized by the WG as key to the successful implementation of Welsh language services (WG, 2016).

Several stakeholders raised concerns regarding the readiness of organisations to comply with the new legislation. These apprehensions included the capacity of the workforce to deliver Welsh language services, the capacity of internal systems (e.g. electronic databases and paper systems) and the ability to monitor compliance with the WLS. Taken together, these concerns represent the main challenges and barriers faced by meso level service providers in relation to Welsh language services. Nonetheless, the WG appears to be aware of these challenges, and outline methods to overcome these barriers, primarily by improving the planning for the

delivery of Welsh across the public sector, as outlined in the WG's 'Cymraeg 2050' strategy document (WG 2017). While various studies (e.e. Misell 2000, Irvine et al 2006, Prys 2010, WLC, 2014) point to the lack of planning, the WG has produced a number of strategies to implement change across the sector, including the strategic framework *More than just words* (WG, 2012, 2016); with provider organisations reporting progress on a number of fronts. These include, for example, Welsh language and awareness training as well as enhanced data on the Welsh language capacity of the workforce (WG, 2019). Within this strategy, the concept of offering an 'active offer' of Welsh language services has gained traction, but will need to be implemented within broader systems and workforce planning. Nevertheless, workforce planning, particularly the need for the strategic development of bilingual skills, is outlined as paramount for the delivery of Welsh language services. Hence, the expectation that the forthcoming 'Workforce Strategy for Health and Social Care in Wales (HEIW, 2019) will give due consideration to the Welsh language in the education commissioning process by setting targets for the recruitment of sufficient Welsh speakers to meet the needs of service users in Wales; and developing the Welsh language skills of the current workforce.

This is further evidence of the potential to mainstream Welsh as a facet of importance within healthcare, and the multi-pronged approach adopted by the WG of embedding Welsh within various strategy and policy documents. Nonetheless, while workforce planning is presented as a mechanism for further enabling the use of Welsh within healthcare, findings from this study suggest that meso level service providers continue to face barriers to the delivery of Welsh language services. The study also found that shortcomings found within macro level educational policies, where only a minority of children in Wales are educated in Welsh or bilingually (StatsWales, 2017), impede the ability of service providers to offer Welsh language services. This suggests that further work is needed to develop holistic macro-driven systems that enable service users to access Welsh language services. This includes ensuring

that the general educational system in Wales produces healthcare professionals who can administer their duties in both English and Welsh. These measures, in the view of the NHS Confederation, would involve “sustained, targeted and multidisciplinary Welsh Government approaches that extend far beyond the remit of Health Boards and Trusts and have at their core a truly bilingual education system in Wales. This in itself represents an altogether new policy debate beyond the mandate of our members” (NHS Confederation, 2018, p. 11 in NAW, 2018).

The macro, meso and micro framework offers an opportunity to assess the role of various stakeholders in implementing language sensitive services within the healthcare sector in Wales. In an attempt to increase the availability of Welsh language services within healthcare, the WG have adopted a multipronged approach to promote Welsh within the sector. The utilisation of language legislation and bespoke language strategy, as well as the embedding of Welsh within broader legislation and strategy, represents a paradigm shift that has brought language policy within mainstream health policy in Wales. Findings from this study suggest that macro, meso and micro level stakeholders in Wales acknowledge the significance of the Welsh language within healthcare. Whilst the macro (e.g. WG) and micro (organisations representing Welsh service users) call for the greater use of Welsh within the sector, the meso level service providers, who are tasked with providing services in Welsh, point to a number of barriers and difficulties in achieving this goal. Current evidence suggests that meso level service providers have a key role in enabling Welsh speakers to use Welsh within the sector. However, barriers remain within the sector and continue to delay Welsh language provision in many instances. Whilst workforce planning and systems development systems planning are outlined as key methods of improving the reach of Welsh services, salient questions are raised regarding the lack of holistic planning in education and its impact

upon the WG's goal of providing Welsh services within the sector. Furthermore, the omission of primary care from current language legislation suggests a disparity between rhetoric and reality within the healthcare sector in Wales. It can be argued that this omission alone calls into question the holistic nature of language policy and planning within the healthcare sector in Wales.

Conclusions

This paper has highlighted the lack of Welsh language planning within the context of healthcare. It demonstrates that, despite the enforcement of language legislation and standards, there is a long way to go in order to fully provide Welsh language services in Wales. Meso level language planning fully epitomises the tension felt between the macro rhetoric of government legislation, policies and strategies and the micro-level aspirations of service users accessing Welsh language services. More often than not, how services are interpreted and further implemented are often down to organisations at the meso level. This emphasises the key role played by the meso-level as a linchpin within the language planning processes as it implements top down language legislation, policy and rhetoric. In this paper we call for a holistic approach to language policy and planning within healthcare; and recognise the need to incorporate other key language planning components, such as education, workforce and leadership, in order to best deliver service improvements for the healthcare sector in Wales.

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Figure 1 Thematic map of stakeholder perceptions of Welsh language standards and regulations (NAW, 2018, 2019)

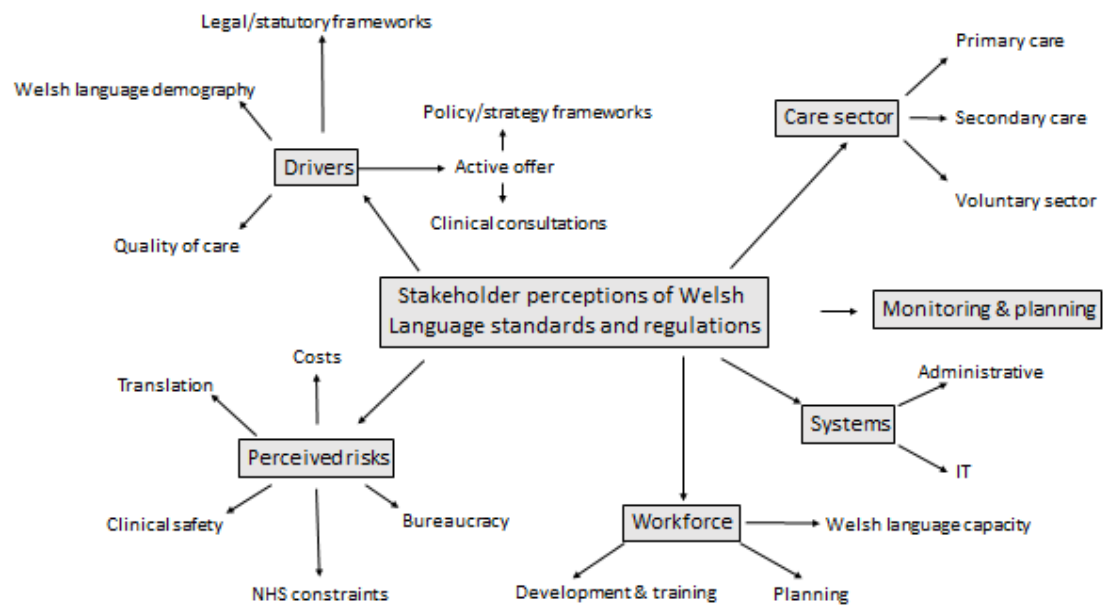


Table 1 The Welsh Language Standards (No. 7) Regulations 2018 (NAW, 2018):

Summary of Stakeholder Concerns

Organisation	Main Concerns
NHS Confederation	<ul style="list-style-type: none">● Challenges due to current constraints in NHS – rising demand, increasing costs, recruitment challenges● Workforce planning and training● IT systems● Financial costs
BMA Cymru Wales	<ul style="list-style-type: none">● Negative impact on recruiting GP/GP trainees to Wales● Cost implications for GP practices
Cymdeithas yr Iaith Gymraeg	<ul style="list-style-type: none">● Abolition of draft standards re Welsh language provision in clinical consultations● Exemption of out-patient services● Exemption and accountability of primary care services
Meddwl.org	<ul style="list-style-type: none">● Abolition of draft standards re Welsh language provision in clinical consultations● Exemption of out-patient services● Exemption and accountability of primary care services
RCGP Cymru Wales	<ul style="list-style-type: none">● Negative impact on recruiting GPs to Wales● Workforce planning and training

Table 2 The National Health Service (Welsh Language in Primary Care Services) (Miscellaneous Amendments) (Wales Regulations 2019) (NAW, 2019): Summary of Stakeholder Concerns

Organisation	Main Concerns
BMA Cymru Wales	<ul style="list-style-type: none"> • Undermines Welsh language use and confidence of staff • Cost implications of translation requirements • Constraints staff release for training purposes • Meeting language preference reliant on Welsh language capacity of staff
British Dental Association	<ul style="list-style-type: none"> • Revised duties proportionate and achievable, assuming they do not incur extra cost (or time deficit) for practices • Added bureaucracy and costs considering current NHS constraints • Cost implications of translation requirements • Negative impact on recruiting dentists to Wales
Community Pharmacy Wales	<ul style="list-style-type: none"> • Negative impact on recruiting pharmacists to Wales • Risks to patient safety of Welsh-medium information leaflets and labelling of medicines • Cost implications of translation requirements
Optometry Wales	<ul style="list-style-type: none"> • Risks of conducting clinical examinations in Welsh • Constraints of translation services

<p>Cymdeithas yr Iaith Gymraeg</p>	<ul style="list-style-type: none"> ● Insufficient rights to Welsh language provision in clinical consultations ● Insufficiencies re extent and transparency of Welsh language services ● WG systems insufficient to monitor Welsh language provision
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Figure 2 Extending the Macro-meso-micro Framework

